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CYANOSIS.

BEING REMARKS MADE IN THE DISCUSSION OF DR. LEWIS
SMITH'S PAPER AT THE STATED MEETING OF THE
N. Y. ACADEMY OF MEDICINE, HELD
MAY 14, 1868.

By A. JACOBI, M.D.,

PROF. OF DISEASES OF CHILDREN AND INFANTILE PATHOLOGY AT THE
N. Y. COLLEGE AND CHARITY HOSPITAL, N. Y.

I CLAIM that the profession is under great obligations to Dr. Smith for having prepared his paper. Medical publications have been replete with single cases of Cyanosis for twenty-five years past, but complete reviews of a large number of cases have been very rare. It is true that some such are to be found in text-books and some in medical journals, but the collection of cases made by Dr. Smith is, as far as I know, as great in number as can anywhere be found. Dr. Smith is modest enough to excuse himself for writing such a paper, but when we still see in one of the latest books on diseases of children, Dr. Tanner's, that it is laid down that the cause of cyanosis is the patency of the auricular septum, there certainly is call enough for such a paper as that which we have come together to discuss.

There are parts of the paper of such excellence that I deem it altogether unnecessary to use up time in going over the ground again. I wish, however, that I could say the same of those portions of the paper which treat of the definition of cyanosis, and its etiology and pathology.

First, the Dr. says that "cyanosis is actually a blood disease;" that "its pathological state may be expressed as follows:—Blood venous in character in the arteries as well as veins. It would be better did its name express its nature, as in leucocythemia, but medical nomenclature is generally defective. A symptom or appearance is often selected as a name, and no harm is really done, provided we are not led into the belief that this symptom or appearance is the disease itself." This then would be my first objection to the paper, that cyanosis is taken as a disease, the true character of which is due to nothing save the condition of the blood. In another place the Dr. says that "there seems to be a tendency on the part of some to ignore cyanosis as a disease;" if that is a tendency really manifest, I believe it to be a very good one.

The Dr. gives 14 distinct malformations which are capable of causing cyanosis, and besides, mentions other conditions capable of inducing it, such as overloading the stomach, violent exertion, etc.; and finally, on page 316, he details the causes of death in cyanosis, which it must be admitted are very variable. We have in this catalogue, dyspnoea, convulsions, apoplexy, hæmorrhage, phthisis, exhaustion, coma, cerebral irritation, effusion into the cranial cavity, thoracic inflammation, diarrhoea, scarlet fever, croup, and so on, and so on. Now I believe that when we have fourteen malformations, every one of which may be the cause of cyanosis and a number of other diseases, which may be the cause of death, we have no right to look upon cyanosis as a disease *per se*. He says: "It would be better did its name express its nature, as in leucocythemia," etc. Now the term leucocythemia means nothing but white-bloodedness: it is simply a condition in which the normal relation between the red and white corpuscles is changed in a certain manner. There are now, too, two varieties of this same leucocythemia, which it has been found necessary to make, in order to express the precise condition of things which exists with this symptom (for it is only a symptom), viz. the splenic and the lymphatic. Therefore, Dr. Smith's comparison is not tenable. During the last century the diagnosis of a case was considered as made when it was called dropsy. Nowadays none of us would make such a diagnosis; we would be ashamed to do no better.

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There are a number of cases of cyanosis that terminate fatally within a very short time, and though during life we may call it cyanosis, we will find after death that the cause had been either lobular pneumonia or atelectasis. We then have it proved to us that cyanosis was but the symptom of the protracted difficulty that existed. Thus, in my opinion, the attempt on the part of Dr. Smith to prove that cyanosis is a new disease, is only an evidence of a retrograde movement in medicine.

As our object in the discussion of any subject is to arrive at the truth by the free expression of opinion, I shall take the liberty of alluding to what I consider the weak points of the paper. One of the weakest points in the paper is that which treats of the etiology of the disease. The Dr. says:—"The cause of the malformation on which cyanosis depends is wrapt in much obscurity. Sometimes mothers attribute it to strong mental impressions felt during utero-gestation. The mother of a patient treated by Dr. Peacock stated that, 'two months before her confinement, she was frightened by seeing a child killed, and never recovered from the shock she sustained.' In another case 'the mother was much out of health, and stated that, when pregnant with the child, she was greatly alarmed by seeing a man who was dying of asthma.' In another instance the mother was frightened at the fifth month of pregnancy; and in still another case, recorded by Dr. Peacock, the mother, four or five months before her confinement, 'was greatly alarmed by her husband, who was insane, standing over her for two hours with a loaded pistol.'" Now it would be better for Dr. Smith, before he gives credit to, or barely mentions such causes, to go a little into the study of embryology. It is not necessary to go into this subject to any great extent to know that first there is a period of development in which there is no septum whatever, either in the ventricle or auricle. The formation of this septum belongs to the first few months of fetal life: the formation of this septum is sometimes not complete, and sometimes differs a little as to its position. When the auricular septum is not complete, we have the foramen ovale remaining open, or we have no septum, or we have, in the case of the ventricular septum remaining open, a perforated septum ventriculorum; or we have no pulmonary artery, but only an aorta, and so on. As to their position, the septa may be found either too far to the right or to the left, and thus give rise to the abnormal origin or transposition of blood-vessels. Where the auricular septum is found too far to the right, the inferior v. cava is found to discharge its contents into the left auricle. Where the ventricular septum is found too much to the right side, the pulmonary artery originates from the left ventricle, or from both the right and left. Where the same septum is found more to the left, the aorta originates wholly or partially from the two ventricles. In this case there may be also a vicious development of the ventricles themselves. The third period of foetal development must be considered as directly introductory to later life: the v. cava inferior moves to the right, the valve of the foramen ovale fits the margins of the foramen, the former aorta ascendens is transformed into aorta, the descendens into pulmonary artery, while the ductus arteriosus Botalli decreases in size. Where the vena cava inferior does not extend sufficiently to the right, the valve, being only a duplicature of the living membrane, does not cover the foramen entirely; it then remains open. Where, however, the reverse position takes place, the foramen will close too early.

At this period, also, must be sought the first occurrence of atheromatous degeneration and incompetency of the valves, with or without either contraction or dilatation of the orifices; also, a number of anomalies in the character and size of blood-vessels, especially the pulmonary artery. There are two anomalies in its case, which have frequently been confounded with each other: the obstruction or contraction of the conus arteriæ pulmonalis, which is very frequent, and the contraction of the ostium. The latter will result from nothing but inflammation and contraction of

the valves, and their ring of insertion. The former, also, must not be taken as a simple arrest of development, but as the result of an inflammatory process. Simpson already believed in inflammation as the cause of these arrests of development; Bouillaud attempted to localize inflammation in the lining membrane, thus attributing those anomalies to endocarditis; and, finally, Dorsch has proved to my satisfaction that the conus arteriosus of the right side is principally due to inflammation of the muscular substance, myocarditis proper. When this process takes place in very early foetal life, its residues may disappear, nothing being visible afterwards, except either a very narrow slit or complete obstruction of the pulmonary artery. In the majority of cases, however, a hard and dense tissue is found, a cicatrix of fibrous tissue, indicating the last stage of the process. It is true that no recent case is on record, but only such in which the process has run through its full course. But this fact is easily explained by the other fact, that this inflammatory process includes very little, if any, danger for the continuation of foetal life to its normal termination, thus depriving us of every opportunity of seeing a case in its first stage. It is but natural that, by the described anomaly, the development of the conus arteriosus is arrested; at the same time the foramen ovale is kept open by the blood being not expelled with sufficient ease, and the valves of the pulmonary artery, and the artery itself, remain delicate and small. At the same time, and from the same cause, the formation of the ventricular septum is interfered with—I speak of that early period in which the formation of this septum is barely commenced with—and the aorta will be found to originate from the two ventricles at once. This anomalous origin of the aorta results in the necessity of its supplying and controlling, in later life, both the large and the pulmonary circulations.

What do we know of the remote causes of all these anomalies depending on myocarditis? Very little indeed; not more, in fact, than of the remote causes of the majority of other diseases in extra-uterine life. But it may be noticed as a remarkable fact that, almost without exception, the malformations of the heart of the new-born, of whatever nature, are found in its right side. This fact must be explained by the physiological action of the right heart, which by far exceeds that of the left, from the well known laws of foetal circulation. Thus, I have no other explanation to offer but this:—That the cause of morbid changes and functions must be sought for in its physiological over-exertion. Whatever organ or part of the system has to make the greatest efforts, to undergo the greatest exertions, is always most apt to exchange its physiological condition for a pathological one.

I cannot leave the subject without alluding to the several theories proclaimed as the true explanations of every one of the numerous cases of cyanosis, viz:—

1. Obstruction of venous circulation.
2. Mixture of arterial and venous blood, and
3. Want of oxygenization.

I claim that not one of these theories suffices to explain every single case of cyanosis. It will be readily understood that a single exception to a rule proclaimed as general, would reverse the assertion of uniformity in the cause and character of cyanosis.

It is true that many cases of cyanosis originate in venous obstruction depending on overloading the right heart, or at least it can be said that in many cases this obstruction and even enlargement of the veins can be found. This was especially distinct in the case of a cyanotic child who died at Ward's Island, some five years ago, at the age of five years. It was a case of absence of the pulmonary artery, the aorta originating in the two ventricles. I owe to the kindness of Dr. Simrock, then a resident physician of the Emigrants' Hospital, the specimen, together with some notes concerning his ophthalmoscopic examination of the retina of the patient, made some time before death. He says:—"The ophthalmoscopic examination of the eyes of the cyanotic child revealed an enormous but equally dis-

tributed dilatation of all the veins of the retina, to such a degree that up to the most peripheric ramifications their width appeared to have doubled, and even more. In short, their calibre was so much enlarged that I have never seen its equal or similar. The arteries of the retina were of the normal size. The retina appeared a little more red than usual, but could not be termed cyanotic, as it showed nowhere the least bluish tinge; nor was the color of the veins blue, but of a dark reddish tinge. No pulsation of the vessels of the retina could be seen, unless artificially produced. Otherwise, the condition of the retina in both eyes was normal. The vessels of the choroid could not be perceived."

But there are a number of cases of congenital contraction of the pulmonary artery in which no cyanotic hue was perceptible during life. Nor do we know else but that in common cases of overloading of the right heart, local congestion, and hemorrhages, or anasarca, or diarrhoea, and the other symptoms of intestinal catarrh, or varicose dilatation of the hæmorrhoid veins, or headache, etc., according to the locality and power of venous obstruction, all these symptoms are found rather more frequently without than with cyanosis. It has been stated, however, that the slowness of circulation in the newly born is such as to give rise to cyanosis before dropsical symptoms can set in. This is not so. We all know the slowness of circulation in an attack of syncope; the surface is pale, but not in the least cyanotic. And the single case of Duchek's, of an infant of three days suffering from all the symptoms of general dropsy, in consequence of disease of the right heart, without being cyanotic, would reverse the plea of slow circulation.

Further, the theory of the admixture of arterial and venous blood, supported by Gintrac, Corvisart, Gendrin, Aberle, Hope, etc., is not applicable to all the cases of cyanosis. There is the case of Bresschet, in which the subclavian artery originated directly in the pulmonary artery. In that instance the arm was supplied with venous blood, but yet there was no local cyanosis. There is another case of Rees, where the abdominal artery originated in the pulmonary artery, but nevertheless there was no cyanosis in the corresponding locality. This is a strong argument against the second theory. And, furthermore, we know that in the fœtus there is a constant commingling of what may be called arterial and venous blood, and nevertheless there is no cyanotic hue on the surface of the fœtus. Again, we have the cases reported by Bizot, Rokitsansky, and many others, of large openings in the auricular septum, and no cyanosis. Lacroix found an opening of the size of a five-franc piece, and no cyanosis; Zehetmair found a heart without a ventricular septum, and no cyanosis. I take the liberty of here showing part of the heart removed from the body of a woman of about 50 years, in the dissecting-rooms of the New York Medical College. There are two openings in the auricular septum, one one-sixth, the other one-fourth of an inch in width, and no cyanosis. But I state at once, that the openings are oblique, and were certainly closed by the bilateral pressure of the blood during the systole of the heart.

The question is—How such a mixture could go on at all? Generally, whenever the foramen ovale was found open, or a deficiency in the septum of the ventricle, it was taken for the full cause of cyanosis; but as far as the foramen ovale is concerned, I have to state that in 1000 cases of post-mortem examinations but 440 were found to show some perforation of the foramen ovale, and in none of these 440 cases was there cyanosis. There are a number of cases in which the foramen ovale was an inch large in the adult, and yet there was no cyanosis. There was no cyanosis in cases where the ventricular septum had a perforation of one-quarter to one-half in diameter. How is this? It simply shows, that the contraction of the two sides of the heart is simultaneous—each one of the two has the same amount of work to perform, and consequently the different currents are not disturbed. If, however, the amount of contraction

is unequal in consequence of valvular diseases, or hypertrophy of one side, this equilibrium is not kept, and we accordingly have a commingling of two currents.

In consequence of the many objections to the universality of the mixture theory, it has been given up by the majority of medical writers. They followed the same erroneous impression which prevails in Dr. Smith's paper, that, necessarily, there must be a common essential cause to all the cases of cyanosis. With the same reason you would have to look for one and the same anatomical cause in different cases of anasarca, or diarrhoea, or hæmorrhage. In order to show how wrong they are, and how little Dr. Smith's theory will stand a thorough examination, I present a specimen taken from an intensely cyanotic girl of five years. In this heart, which is of normal size, the two ventricles are of nearly the same size; the right auricle is but the common sac for the normally developed veins. The pulmonary veins are fully developed, showing that they have always been swelled with a normal amount of blood. There is not a single abnormal valve, every one being competent. The aorta is very large up to the arch, and originates in the two ventricles; its valve is competent. Its size diminishes in the same degree as it sends off a large number of large bronchial arteries (in the specimen you count twenty-two), which have to supply the lungs with blood in lieu of the pulmonary artery, which is too small to carry more than one-fifth of the normal amount of blood, but is normal otherwise. The numerous and large bronchial arteries are evidently fully sufficient to supply the lungs. The size of the pulmonary veins, moreover, proves that they have their full duties to attend to. There is no symptom of overloading of the heart; there is, in fact, nothing which "prevents the free and regular flow of blood to, through, and from the lungs." And yet there was the most intense cyanosis I have ever witnessed. After having examined this specimen repeatedly and scrupulously, and submitted it to the most critical examination of medical friends, as I herewith do to yours, I claim it as a proof of my assertion, that this was a case of cyanosis depending on the mixture of arterial and venous blood. Thus I wish you to dispose of those who gave up the mixture theory because it did not explain every case, and selected another not more satisfactory; and also of the theory of Dr. Smith, who says, that "cyanosis is due to vices, or defects in the organism, usually congenital, which prevent the free and regular flow of blood to, through, or from the lungs." When we think of the large number of bronchial arteries supplying the lungs, and of the numerous collateral ramifications from the intercostal and internal mammary, which assume the same function by taking the place of the pulmonary artery—vessels which Dr. Smith kindly believes to be generally overlooked by other anatomists—and further, when we bring into account the usually normal size of the pulmonary veins,—all of which you will also perceive in two other specimens I have with me: Dr. Smith's theory is simply reduced to the old theory of Billard, Hunter, Sandifort, Nevin, and others. This theory explains every case of cyanosis by deficient oxygenation, no matter whether the local cyanosis depending on local compression of veins could be explained by this theory or not; nor that the foetus is not cyanotic, although greatly inferior in the amount of oxygen contained in the maternal blood.

It is true that the majority of malformations cyanosis is found with, fall under the head of Dr. Smith's theory. But if his theory was the right one, we ought to see cyanosis in every case where circulation to, through, and from the lungs is effectively interfered with; thus, in every serious case of pneumonia, particularly when bilateral, emphysema, and a number of valvular diseases. This, however, is not so. Thus the theory of Dr. S. is inconsistent with true pathology for two reasons: 1stly, because there are cases of cyanosis which evidently have other, and distinct causes; and 2ndly, because in many cases in which the anatomical condition required by his theory is present, there is no cyanosis.

I say again, that any theory which is to yield a universal explanation of, and to be identified with cyanosis, must not allow of a single exception. Every single case explainable by other causes diminishes, or rather destroys the probability or possibility of its being the true theory. And thus, as hitherto, we shall have to explain the symptom called cyanosis, sometimes by an obstruction of circulation, sometimes by the mixture of arterial and venous blood, sometimes by deficient oxygenization, and at other times by a complication of two or more of these causes. It may even happen that we have to call in other, more subordinate causes. Who, for instance, can tell whether or not the deficient nutrition of the nervous system, and particularly of the pneumogastric and sympathetic nerves, resulting from the mixture of arterial and venous blood, may not bring on a retardation of peripheric circulation without the presence of a mechanical obstruction?

Medical science has long attempted to become free from terms indicating a symptom or a complex of symptoms, which formerly assumed the dignity of diseases in the vocabulary of pathological anomalies. Where we are enabled to arrive at an anatomical diagnosis, we do not make use of such terms. Thus many a case which formerly would have been called cyanosis in a newly born, is at present congenital pneumonia, or atelectasis, or incompetency of a valve, with cyanosis among the accompanying symptoms. In the same manner we do not diagnosticate dropsy, but a distinct cardiac disease, or fatty degeneration of the kidneys, or cirrhosis of the liver, etc., with dropsy among the symptoms.

I claim, then, cyanosis as a common symptom of a number of different anatomical lesions, either congenital or acquired, and deny its essentiality as a disease *per se*.

Original Communications.

IS ANTE-FLEXION OF THE UTERUS,

WITHOUT LEUCORRHOEA OR ENGORGEMENT AND ULCERATION,

A PATHOLOGICAL STATE

REQUIRING SPECIAL REMEDIAL TREATMENT?

By S. OAKLEY VANDERPOEL, M.D.,

OF ALBANY, N.Y.

Of late years a great impulse has been given to the progress of uterine pathology. The study of the ovum and its development has been greatly perfected, while the improved methods of exploration have enabled pathological states to be readily and promptly recognised. It is, however, in the observation of organic lesions and their remedial agencies that the greatest progress and true amelioration may be said to be attained. The boon to humanity conferred in this study by a few earnest, noble men, we consider inestimable. In acknowledging fully this obligation, let me not be misunderstood if I criticise strongly that disposition, I might say *fashion*, now so prevalent in the profession, to see in every ailment which the female presents a *uterine* disease, and find in every accidental condition which the uterus presents, upon an examination by the speculum, the *fons et origo* of all her ailments. So fashionable is it, that nearly every village, certainly every water-cure establishment, has its doctor who dexterously uses the speculum, and who faithfully applies his caustic to the inflamed follicular surface of the cervix with the same industry that a few years since it was applied to the fauces, to neither of which would any permanent benefit result unless at the same time the depraved condition of the general system was improved.

Progressing on this one-idea theory, the different accidental positions of the organ have been persistently treated; some employing the ingenious contrivance of the stem pessary and its resulting tortures; others, the daily

straightening the uterus by introducing one finger into the vagina and another in the rectum or over the pubes, according to the nature of the deviation. It seems hardly credible so absurd a process as this latter should be gravely pursued. We certainly have more respect for the man who administers his infinitesimal dose of oyster-shell than for the one who will for weeks practise this latter upon his confiding patient.

It is the object of this paper to inquire how far one of the most commonly assigned deviations, viz. "simple ante-flexion of the uterus," without engorgement or ulceration of the cervix, and without any leucorrhoeal discharge, may be considered a pathological condition demanding special remedial appliances. We answer, a condition of the organ presenting the above characteristics does not require special remedial appliances. Further, that when presented in a patient with enfeebled system, she will recover equally well without them; that, when recovered, the vicious condition of the organ may continue without inducing disturbance, or in any way affecting the general health. According to careful researches of M. Soudry, conducted under the supervision of M. Barthéz of Paris, ante-flexion may be considered almost the normal condition prior to puberty. Twenty-three per cent. of those examined presented this condition of the organ. It becomes less and less frequent after puberty, and disappears where pregnancy has occurred. This condition, then, so constant in early life, should not excite surprise if discovered in the female who has never been pregnant. M. Aran explains this state as follows: "This ante-flexion of the uterus has really nothing mysterious or difficult to understand; it is nothing more or less than the result of pressure exercised during foetal life by the abdominal viscera upon the still soft and little resisting part of the uterus; that is, upon the body, when that organ is still inclosed in the abdominal cavity proper." If, then, ante-flexion prior to puberty may be regarded rather as the normal state, surely its presence after this period, where no conception has occurred, and where no indications of suffering of the organ, as indicated by engorgement or ulceration of the cervix, or uterine leucorrhoea, present, need not be considered a pathological state demanding special remedial agents. Rather should it be the aim of the physician to foster that instinctive delicacy, the charm and attraction of the sex, than by daily manipulation blunt the finer elements of her nature.

We have, in addition, the testimony of late writers upon this subject; M. Aran, in his clinical lectures on "Maladies de l'Uterus," says: "Flexions of the uterus have not, in general, as unhappy an influence upon the health as many other uterine affections. Many females carry them all their life without notably suffering therefrom. Some appear more innocent than others, such as ante-flexions and latero-flexions of the body of the organ; the different flexions of the uterine neck—"

Scanzoni, than whom a more careful and truthful observer, or a more clear and concise delineator, has not written, says: "In the commencement of our practice we were ourselves of the number of those who, as Kiwisch, Mayer, Simpson, Valleix, and others, could not too highly estimate the baneful influence of flexions upon the whole constitution of the sufferer. We avow even that it is not without difficulty to renounce an opinion which even to this day has been considered by a great number of our most illustrious confrères as one of the greatest advances of our science. Nevertheless, in view of so great a number of facts proving the contrary, it has been impossible not to change our opinion. So that now we are convinced that flexions of the uterus do not acquire any importance, are not followed by serious dangers, except when they are complicated with some other alteration in the tissue of the organ." It is not of course necessary to enumerate the reasons by which this conclusion is reached.

One point, however, cannot but have struck every practitioner. After rising from the perusal of the careful descriptions given of the different forms of deviation of the

uterus, and profoundly impressed with the necessity of exerting all his skill and energies to their correction, when presenting in his practice, yet in his daily experience he is constantly reminded of the perfect indifference, so to speak, of position which the uterus takes in the pelvic cavity, while the individual is in this part without suffering, or any manifestations of a morbid condition. Sometimes the cervix is almost in the vulva; again, resting on the floor of the vagina, tilted to the pubes, or inclined to either ilium. Shall we arbitrarily assume these as morbid conditions, and place our patient, unconscious of any such state, under specific treatment? Yet such, we fear, is too much the tendency of the day. If innervation be at fault, from imperfect assimilation, and a relaxed tonicity of the muscular system follows, the uterus, through loose attachments and elastic ligaments, is among the first organs to show it by some deviation, yet without any positive exhibition of suffering from the organ itself. Such cases, we contend, do not require local treatment. The uterus, by all appliances, either local or derivative, will never assume its normal position until the tone of the general system is rendered healthy. This accomplished, there will be no call for further local manipulation.

To us it seems absurd to argue against the necessity of either derivative treatment or local manipulation for a simple ante-flexion, without any accompanying signs of suffering in the uterus, did we not know that it was deliberately advised and acted upon. We have seen ladies who, almost daily for three months, were subjected to manipulations for straightening an ante-flexed uterus with the finger; others, anæmic and with deficient innervation, subjected to issues for the same purpose. In either case it was not pretended but that the ante-flexion had existed a long period; if so, the tissue of the anterior wall must be condensed, and that of the posterior extended. Would any such measures produce an equilibrium between them? Analogical reasoning shows its futility.

If suffering does result, and which we do not deny may and does occur, it will be manifested in some manner by the organ itself. Then the treatment of supporting the uterus by some form of stem pessary, would seem the only one from which benefit could be expected. Comparatively few, however, can tolerate them, and our experience has been that patients leave the hands of those who have specially treated them for this affection no better in this respect than when the discovery of ante-flexion was first made.

We have been drawn into the foregoing train of thought from the fashionable prevalence of viewing every disease of the female of uterine origin—of studying that whole system of harmonies from a single stand-point, and attempting from that to comprehend the whole.

Much as we extol and commend the principle in some departments of the profession, of devoting the time and energies to a single branch, there are others in which it degenerates to a one-idealism, and belittles rather than enlarges the domain of our science. To such tendencies we must enter a stern protest. While the uterine system is the starting-point from which sympathetic suffering radiates over the whole system, it is quite as often but secondarily implicated. It should be the duty of the honest interpreter to give such condition its true signification, not unduly elevating a slight pathological condition into an explanation for long continued and severe sufferings in other organs.

Sept. 30, 1868.

M. DEBOIT says that sugar is an excellent destroyer of worms. He once accidentally put sugar instead of salt on a leech which he wished to detach from the skin, and was surprised at the spasms produced by it. He therefore tried sugar on earth-worms, and found it had a similar powerful effect; and has since used it in solution with success as an injection in children.—*Brit. Med. Jour.*

REMOVAL OF BROKEN CATHETER

FROM BLADDER.

By SURGEON C. S. MUSCROFT.

MEDICAL DIRECTOR, U.S.A.

JACOB SHEETS, a corporal of Co. I, 101st Ohio Vol. Inf., was admitted into one of the hospital depots of the 3d (Maj. Gen. Rosser's) Division, 14th Army Corps, in the Dept. of the Cumberland, on the 1st day of January, 1863, having been wounded on the day previous by a ball (supposed to be a minié) at the battle of Stone River.

The ball entered from behind at the inferior border of the gluteus maximus muscle an inch and a half to the right of the median line, and passed obliquely forward and upwards, wounding the urethra in the posterior third of its spongy portion; then making its exit at the superior portion of the scrotum half an inch to the left of the raphe, it having passed through the superior third of the left testis. When the patient was first admitted, his penis and scrotum were enormously oedematous, with ecchymosis extending above, over nearly the whole of the hypogastric and iliac regions. When he attempted to urinate, the water flowed freely from the wound anteriorly; consequently he had voluntarily retained his urine for twenty-four hours. A silver catheter was now introduced, and the contents of the bladder evacuated, after which a gum elastic catheter was substituted, and left in the urethra, being confined there by suitable dressings. The catheter was so arranged as to conduct the urine into a glass bottle. Compresses wet with cold water were applied to the inflamed parts.

Jan. 3d.—The scrotum appeared nearly the same as on the first, except that it was softer and fluctuating. The penis was still swollen, discolored, and cedematous. Two incisions were made through the covering of the testes into the sac of the tunica vaginalis. The discharge of pus and fetid urine was abundant.

Jan. 5th.—The ecchymosis in and about the penis was much diminished, but a portion of the scrotum was evidently gangrenous. A line of demarcation had formed on the seventh, and on the tenth had separated, leaving the testes bare to the extent of nearly the whole of their anterior surface.

Adhesive straps were then applied to the remaining integument of the scrotum, drawing the edges together as near as possible, to form an anterior covering.

About this time the urine became loaded with sediment, leaving a light colored gritty deposit on the end of the catheter which protruded into the bladder, also filling the whole of the length of its tube, preventing the passage of urine.

This was removed, and another introduced. In three days, it became filled with deposit in like manner to the former one, and another of smaller size (which was the only one at hand at the time) was introduced.

On the following morning (the 25th) I was called to see the patient, and found that the catheter had been broken off about midway; the distal end, which was the longest, having fallen out of the urethra, the other remaining in, the outer end of which could be distinctly felt with a probe.

In this emergency I called upon Surgeon C. S. Muscroft, the Medical Director of the 3d Division, who readily responded, bringing with him a long, straight, narrow bullet forceps, which was the only instrument in his possession that promised any success in the extraction of the remnant of the catheter. The patient was put under the effects of chloroform, when it was found on examination, that the remaining end had receded behind the symphysis pubis into the membranous portion of the urethra, and could not be reached with the straight forceps. Here Dr. Muscroft ingeniously improvised a curved forceps by heating those he had in the stove, and bending them to the proper curvature over the window-sill. The patient being still under the influence of chloroform, the forceps were again intro-

duced, and after persevering efforts, the broken piece of catheter was nicely and firmly grasped, and extracted.

The catheter was not again introduced, but pressure with compresses and adhesive straps was made around the urethra with a view to re-establish the natural urinary channel and obliterate the fistulous opening.

This was successfully accomplished. The urine was voided freely from the meatus externus, none escaping at the wound.

On the 27th, the patient had a heavy chill, and on the following day complained of great pain in the perineum at the right and lower portion; a slight degree of redness and swelling was perceptible. On the fifth day following, an abscess had formed, which was punctured, and discharged a large quantity of pus. From this time forward the patient steadily improved, and was discharged from the hospital cured.

THIRD DIV., 13TH A.C.,
DEPT. OF THE CUMBERLAND.

B. C. BRETT,

Assist. Surg. 21st Reg. Wis. Vol. Inf.

EXPULSION OF TAENIA BY THE PUMPKIN SEED.

By THOS. M. FLANDRAU,

SURGEON 146TH N.Y. VOLS.

In the case of a girl, *æt.* 12 years, I administered two ounces of the pumpkin seed, grated with half a pint of sweetened water, after a fast of thirty-six hours. Nothing but tea was allowed during this period. One ounce of castor oil was taken two hours after the seeds.

About twenty feet of the tape-worm were passed during the action of the cathartic.

As I left town to rejoin the army on the day the prescription was made, I am unable to state whether the head of the worm was evacuated. No other vermifuges had been used.

A protracted fast being regarded as an important point in this method of expelling tænia, it is perhaps worth the trial to decide what would be the effect of the castor oil, so given, without the pumpkin seed.

CAMP NEAR CULPEPPER C. H., VA.,
Oct. 8, 1863.

TWO CASES OF HOSPITAL GANGRENE,
OCCURRING WITHOUT PREVIOUS WOUND.

By FRANK H. HAMILTON, M.D.,

PROF. MILITARY SURGERY AND FRACTURES AND DISLOCATIONS
IN THE BELLEVUE HOSPITAL MEDICAL COLLEGE, N. Y.

CASE I.—General Hospital No. 4, Nashville, Tenn. Wesley Frost, of the 85th Illinois Vols., was convalescing from a severe attack of pneumonia, when, about the twenty-second of March, 1863, a small vesicle appeared upon the front of his right leg, where the skin was perfectly sound. This soon dried up, became black, and the sloughing commenced.

This man had never had syphilis, or any other constitutional specific malady, but at the moment of his attack he was exceedingly feeble. There were at the same time two or three cases of hospital gangrene in an adjoining ward, but none in the ward which he occupied.

On the fourteenth of April, when my attention was first called to him, the gangrene had been corrected by bromine, but the ulcer covered eight inches by four of superficial surface, and the shaft of the tibia was dead.

Some time during the month of August, by the courtesy of the surgeon in charge of the hospital, I was permitted to remove the dead bone, which was found to include all, or nearly all, of the tibia intermediate to the epiphyses. I have seen him several times since then, and find the wound cicatrizing finely, and his general health steadily improving.

II.—On the 26th of March, 1863, I saw, in General

Hospital No. 7, at Louisville, Ky., a Confederate soldier, Travis Austin, with two large ulcers, one upon the right wrist and the other upon the right leg, near the ankle, both ulcers being the result of hospital gangrene, which had been arrested by the use of bromine, applied as recommended by Dr. Goldsmith.

I was informed that he had not been wounded, but that he was admitted on the fifteenth of February, 1863, with purpura hemorrhagica. He had been living a long time without fresh vegetables, and he was no doubt scorbutic. The gangrene commenced almost simultaneously both upon his wrist and his ankle, as a small pimple, from which point it rapidly spread.

DISLOCATION OF THE SECOND PHALANX OF THE GREAT TOE.

By J. M. CLEAVELAND, M.D.,

OF THE STATE LUNATIC ASYLUM, UTICA, N. Y.

CARSTEN HOLTHOUSE observes that "dislocations of the second row of phalanges (toes) are so rare that Malgaigne could find but two examples of the accident on record; one was a compound dislocation affecting the great toe, and the other the third toe." See *Holmes's System of Surgery*, p. 672, vol. ii.

I give you the following case, not knowing whether the silence of the records referred to be owing to the rarity of the accident, or to its insignificance.

J. C., aged 38, a stout muscular man, a patient in the State Lunatic Asylum at Utica, being teased by a fellow-patient, ran after the latter, and dealt him a kick with his right foot, on which he wore a slipper. He suffered neither pain nor inconvenience in walking until six hours afterwards; when the great toe of the right foot became swollen, red, and acutely painful. On examination the great toe was found to be shortened, and the second phalanx dislocated backwards, and the extremity of the toe inclined upwards and slightly towards the second toe. Under iced water-dressings for two or three days the pain and swelling so far subsided, that reduction was easily accomplished.

CASE OF IMPERFORATE ANUS; THE BOWEL TERMINATING IN THE URETHRA.

By H. P. STEARNS, SURGEON U.S.V.,

IN CHARGE OF U.S. GENERAL HOSPITAL OF PADUCAH, KY.

I WAS asked, September 20th, by one Mr. Miles, to visit his child, and, if possible, relieve it by an operation, as there was no "outlet," as he expressed it, for the contents of the bowel.

I found the child, a well formed male, of about eight pounds weight, perfect, with the exception of the anus. The bowels were somewhat distended, and the child appeared to be in some pain, and was apparently making efforts to discharge the contents of the intestine. Chloroform was administered by my friend, Dr. L. S. Horton, and I proceeded to dissect through the integument or semimucous membrane, and carried the dissection about one inch and a half, finding no rectum or bowel. By introducing the finger I was able to distinctly feel the movement of the contents of the abdomen at each inspiration, my finger resting upon what I judged to be the peritoneum. As nothing could be felt indicating the location of the bowel, I came to the conclusion that it probably terminated in a *cul-de-sac* in some portion of the colon. If this should not prove to be the case, I thought it possible that, as it became more distended, it could be felt by the finger, and, consequently, introducing a tent, I left, promising to see the child again the next day.

Upon my next visit I observed something about the penis which appeared to be fecal matter, and the attendant said that the child had passed fecal matter from the penis with much effort. No bowel could be felt through

the dissection which I had made, and I consequently left the result to nature, supposing the child would only survive a few hours. It died the next day at eleven o'clock A.M., having lived three days, and, as the attendant informed me, had three distinct fecal discharges by the urethra. Six hours after death I made an examination, and found all parts normal except that the bowel terminated in the urethra, entering it just in front of the prostate gland. I should add that the genitals were much larger than is usual, being of the size of those of an ordinary child eight years of age.

PADUCAH, KY., Sept. 30, 1863.

Progress of Medical Science.

PREPARED BY E. H. JANES, M.D.

PREVENTION AND CURE OF PUERPERAL INFLAMMATIONS.

WHILE there exists a greater or less mortality in childbed, the subject of its causes, prevention, and cure, cannot be too faithfully studied by the medical man. An elaborate paper on this subject, by DR. ROBERT JOHNS, is published in the last number of the *Dublin Quarterly Journal of Medical Science*, founded upon many years' experience and observation, in which we are told that in by far the greater majority of instances, especially in private practice, *post partum* inflammation is either induced or overlooked by the medical attendant, from want of practical knowledge or attention on his part, or from neglect or violation of his directions by the nurse, by the patient, or her friends. In addition to his own observation, he is supported in this remark by such authority as Drs. Denman, John Clarke, and White. Without presuming to discuss the pathology, or to recommend any new specific for the treatment of the disease, the object of the paper is to point out some of the principal causes, and show how they may be avoided, or, failing to prevent the disease, to point out the best means for removing it. He views prevention in a twofold light: in one, our object being to avoid or remove predisposing causes; and in the other, when these causes have obtained, to counteract their baneful influence by adopting that treatment most likely to ward off the anticipated danger; and this he believes is best effected by adopting as a prophylactic—though less actively—the most powerful of those means successfully employed for cure of the disease. Should this fail, we have the advantage of having commenced treatment early in a disease which runs its course so rapidly. Though the causes of post-partum inflammation are numerous, the following are classed among the most frequent and most powerfully predisposing:—1. *Impaired health during pregnancy.* This we should remedy as far as possible by insisting upon the use of proper kinds of food, and regularity in the mode of living towards the end of pregnancy, by paying proper attention to the bowels, and by all means prevent an accumulation of feces. By seeing the patient occasionally, much may be done towards keeping her in good health. 2. *Want of cleanliness and ventilation.* *Hospital influence.* The remedy for this is obvious. The only means of arresting the disease when prevailing in a public institution is in shutting up, cleansing, painting, and thoroughly ventilating. As an example, he mentions the report of the Royal Maternity Charity of London for 1861, in which year 4,110 women were delivered, and 11 died, not one of whom had puerperal fever, while during the same period this disease largely embittered the charity of the London lying-in hospitals. 3. *Contagion. Epidemics.* This part of the subject is not confined to epidemics of puerperal fever and its kindred disease, erysipelas; but typhus, scarlatina, small-pox, physicians engaged in anatomical pursuits, or post-mortem examinations, all furnish abundant source of infection for the propagation of this disease. In support of this, he cites what occurred some years since at the Vienna Lying-in Hospital, where it was the

habit to intrust one portion of the patients to the care of male students, whilst the other portion was attended by females. It soon became manifest that the mortality amongst the former class was far greater than in the latter, which, on inquiry, was found to have resulted from the fact of the male students being engaged daily in anatomical pursuits. They were then superseded by females, after which the discrepancy completely disappeared, and an order was issued, that, for the future, no student so engaged would be permitted to attend. He is so strongly impressed with the truth of this observation, that he invariably refuses either to make or assist at necroscopic examinations, and considers it highly reprehensible for any person so engaged, or in the attendance of typhus fever, erysipelas, or puerperal fever in hospitals, or who is resident therein at epidemic periods, to practise midwifery. Though the disease be epidemic in its origin, we often have sufficient precursory indications to lead us to fear the approach of an epidemic, and thus enable us to make use of such prophylactic measures as are within our power. These indications are, slow recoveries, without being able satisfactorily to account for them, deficiency of pains, irregular and spasmodic contractions, rigidity of the os, and other causes of prolonged labor, which, of itself, is one great source of the disease. This is supported by the evidence of Drs. Collins, Joseph Clarke, and Van Franke. 4. *Distress of mind from seduction and such like; anxiety, and excitement caused by visitors.* The connexion between mind and body is nowhere better exemplified than in the puerperal state; and it is a true remark that seduced females are particularly obnoxious to puerperal fever, which is with them very fatal. Newspaper reports of deaths from this disease, and many stories continually rung in the ears of the poor victim by the anxious but meddling friends, all have their mischievous tendency, and should, as far as possible, be prohibited; also, the too early admission of visitors into the patient's room, while still suffering from that irritation of the system occasioned by the violent efforts of labor. 5. *Errors in diet, and use of stimulants.* From various authorities consulted, as well as from actual experience, it is laid down as a rule that animal food is improper, and ought not to be allowed till after the secretion of milk has been well established, the attendant fever subsided, and the pulse has come down to its natural standard. Stimulants employed during labor induce hæmorrhage; and if taken too soon after its completion, induce puerperal inflammation. 6. *Hæmorrhage; introduction of the hand for version, or retained placenta; portion of secundines retained, or clots putrefied in the uterus.* 7. *Drawing the breast by artificial means too soon after delivery, or repelling the milk too suddenly by cold applications of vinegar, etc.* 8. *Exposure to cold, too early rising, or going out too soon after delivery.* We cannot too carefully guard our patient from exposure to cold, either from too light clothing, or the too abrupt removal of the binder, or from going out for a walk or drive, for at least a month after delivery. This must be apparent to all when we bear in mind that the womb, which before impregnation measured two and a half inches, and weighed about an ounce and a half, and which had at the termination of utero-gestation increased to twelve inches, and attained to the weight of several pounds, could not return to its pristine condition in a shorter period of time. With a view to avoid inflammation, as well as the foundation for future mischief, it is deemed paramount to keep the patient in a recumbent posture so long as we can feel the uterus enlarged above the pubes. 9. *Puerperal convulsions, actual or threatened.* Collins and Denman both allude to this fact, and Dr. Johns has elsewhere expressed the same opinion, which his subsequent experience has proved to be correct. 10. *Uterine disease.* 11. *Inhalation of Chloroform during labor.* He entertains no doubt that this strongly predisposes to puerperal inflammation, producing the disease either directly by poisoning the blood or otherwise, or indirectly by inducing hæmorrhage, or chest affections, already stated to be promoters of the malady. He has already written a paper on this sub-

ject, published in a previous number of the Journal. If we are not successful in avoiding or removing these causes, our next duty is to employ, as a prophylactic, such remedies as have been most successful in treating the disease, regulating the administration by the number and force of existing influences. For this purpose mercury is recommended to be employed in a mild way, commencing immediately after, and in some instances before delivery, and continuing its use until the milk has been secreted. Where the patient has suffered much in the removal of the after-birth, Dr. Collins recommends the use of calomel and ipecacuanha, to be commenced immediately after delivery, so as to be beforehand with inflammatory attack. It is highly important that the treatment should be commenced early, as a few hours' delay may often be the cause of a fatal result; hence the necessity of watching narrowly the condition of the patient, so as to be able to detect the slightest inflammatory symptom, and of seeing the patient instantly if sent for under circumstances that lead us to suspect the slightest danger. The treatment should not only be prompt but thorough. The abstraction of blood is generally requisite, though venesection, owing to the asthenic nature of the disease, is not so often resorted to as formerly. The repeated application of leeches answers better, and does not weaken the patient. Mercury is regarded as our sheet-anchor, and should be given in very bad cases to an extent nothing short of salivation. Owing to the diarrhoea that sometimes accompanies the administration of mercury, Dr. Johns is in the habit of giving it in combination with opium and bismuth, giving the mercury in small doses by the mouth, together with its endemic use. When used in this manner, he has never seen the bowel complaint increased, but, on the contrary, arrested. He knows of no well authenticated case terminating fatally where there were distinct evidences of the system having been affected by mercury. As adjuncts he employs stupes, turpentine epithems, turpentine internally if much flatulence exists, linseed-meal poultices, hot dry bran, and blisters, in some instances dressed with mercurial ointment. Where mercury is inadmissible, or when it has been inefficiently used or neglected, secondary affections are likely to supervene, when quinine with opium, bark with ammonia, chlorate of potash, sesquichloride of iron, broths, and brandy, are indicated.

SYPHILIS IN THE ENGLISH ARMY.—From the Army Statistical Reports it appears that the annual admissions into hospital from venereal diseases amount to 206 in every 1000 Cavalry soldiers, 250 in the same number of Foot Guards, and 277 in every 1000 Infantry of the Line. The average proportion for the Army at home is 267 per 1000, or more than one-fourth of the whole number. It is calculated that on the lowest average each man is fifteen days under treatment. Thus 688 men out of the home force are always in hospital from this cause alone—a number equal, or nearly so, to the strength of a regiment on the home establishment; and the money loss to the State is calculated at nearly £14,500 a year. The further loss from subsequent disease and invaliding, and the injury to the State from the life-long deterioration of the individual and from the hereditary curses of transformed syphilis and scrofula conveyed to future generations, are beyond calculation. In India the case appears worse than in England. The proportion of venereal cases constantly in hospital is usually from 20 to 25 per cent. of the total sick. At some of the larger stations it much exceeds this. At Bangalore and Roorkee the proportion at the time the report was made was 50 per cent.; at Dinapore it was as high as 53 per cent.; and Dr. Maclean testified that a few years ago in the 1st Madras Fusiliers the amount of syphilis was equivalent to the withdrawal from duty of one-fourth of a company daily.—*Lancet.*

Reports of Societies.

NEW YORK PATHOLOGICAL SOCIETY.

STATED MEETING, April 22, 1863.

DR. D. S. CONANT, PRESIDENT, IN THE CHAIR.

OVARIOTOMY.

DR. FINNELL exhibited a mass of ovarian disease removed by ovariectomy from a patient twenty-six years of age. She first came under the notice of Dr. Finnell a year before. The abdominal swelling at that time was very great, and the only relief that could be obtained was by tapping. Four or five gallons were drawn off at the first operation, and about three gallons at the second. At her very urgent request the operation for ovariectomy was performed, notwithstanding the fact that she was very much run down.

The incision was made a little to the right of the median line, four or five inches in length, and a little below the umbilicus. There were some slight attachments to the omentum, which, however, were very easily separated. The pedicle was about one inch in thickness, and about three inches in length; it was drawn out as usual, and secured with a silver wire suture. The tumor weighed seven pounds. On the morning of the second day after the operation the patient commenced vomiting, and experienced considerable pain and tenderness of the abdomen. On the fifth day peritonitis was fully developed, and she died. There was found at the time of the operation, floating around in the abdominal cavity, a mass of false membrane, which evidently was the result of previous inflammations.

DR. CONANT thought it good practice, where the pedicle was short, to bring out the ligature through the vagina by means of a curved trocar. The opening thus made would be large enough to allow the escape of fluids, but too small to admit air.

DR. PRINCE was of the opinion that the ecraseur would be serviceable in cases where the pedicle was short.

DR. FINNELL remarked, that he would be afraid to return the pedicle, inasmuch as, when reaction came on, the danger of hemorrhage would be too great.

DR. SANDS had read of a case reported in one of the English journals where a great deal of violence had been resorted to in order to break up old adhesions, and yet the patient made a good recovery. This was simply owing to the fact that the peritoneum, in consequence of numerous previous attacks of inflammation, had become so altered as not to be susceptible of extensive inflammation. The same analogy holds good in long standing disease of the pleura and of the knee-joint.

OPERATION OF TREPHINING.

DR. CONANT presented a disc of bone removed by trephining from the skull of a boy, with the following history. The patient had been tending the launch of a gunboat, when a hawser, attached to the capstan, broke, throwing him violently against a spar. He struck head first, and remained insensible for three-quarters of an hour, but at the end of that time he became rational, and remained so for three days. On the right side of his head, near the parietal bos, was noticed a soft tumor, but no depression could be made out. On the fourth day there were manifest some typhoid symptoms, and a brisk cathartic was accordingly given. On the sixth day there was noticed a soft tumor on the opposite side of the head, with edges so marked that the physician who saw the case was inclined to think that there was depression of bone. On the morning of the seventh day there was convulsion of the right side, followed by paralysis of the right arm and right side of the neck. There was also a slight convulsion of the right leg. The pupils were very much dilated. On the morning of the

twenty-seventh day after the injury the patient had another convulsion, and Dr. Conant was sent for. The patient was etherized, and the head very carefully examined. On the right side of the head no depression was discovered, but on the left side there seemed to be a slight yielding on pressure. It was determined to cut down in this situation. On baring the bone a fissure was discovered, with blood oozing from it, when it was concluded that a clot which had been very slowly forming existed underneath. A button of bone was accordingly removed, disclosing a blood clot, which, on being removed, it was found that the patient could move his arm perfectly well, and his intellect began to get clear. On the twelfth day he was able to be up and dressed. The pupils are still a little dilated.

REMOVAL OF ENCEPHALOID DISEASE OF THROAT.

DR. CONANT also referred to a case of operation for the removal of encephaloid disease of the throat. The patient was sixty-seven years of age, and the disease had only made its appearance five months previous, but in that time its rapidity of growth was such as to fill up almost the entire faucial orifice. Dr. Conant at first took off about two-thirds of the mass by means of the ecraseur, and at the end of ten days removed the remaining portion. There was a considerable amount of hemorrhage, which, however, was checked by the application of the persulphate of iron. The patient made a good recovery. On examination of the mass after removal, the starting point of the disease was found in the mucous membrane immediately surrounding the tonsil.

The Society then adjourned.

American Medical Times.

SATURDAY, OCTOBER 17, 1863.

PRESENT REMUNERATION FOR PROFESSIONAL SERVICES.

THE subject of remuneration for professional services has always interested the mind of the medical public, and notwithstanding so many discussions have been held upon the question it has hardly yet become threadbare; in fact, it is not likely ever to lose its claim for consideration as long as medicine is practised for a livelihood. We do not, however, wish to discuss the question in all its bearings, but would merely present some thoughts having reference to the present times. Speculators in gold, job stock brokers, contractors, and the like, have so crippled the confidence in the money market that as a consequence provisions, and all the other necessities of life, have risen to surprisingly high rates, so that the actual cost of living is now nearly double what it was nearly two years ago. Every component part of the community feels the burden of this great advance on the price of goods, and the redress is sought in a corresponding demand for an increase in wages. We already have seen that among the lower classes, where the burden is necessarily soonest felt, "strikes" have been so common that almost every artisan can now lay claim to his just dues. It is but proper that every laborer and business man should seek to protect himself by an increase upon his rates; and the physician, viewed in the light of one who is expected to earn his living by the practice of his profession, should not be behindhand in asserting his claims for justice. We maintain that some advance in the present rate of charges should be agreed upon by the profession as a body, in order that they

may protect themselves against such ruinously high prices. To those gentlemen who have large incomes this may not be so seriously felt; but to the young practitioner, whose yearly receipts heretofore have been barely sufficient to maintain him in the style in which he should live, it becomes an absolute necessity, else he renders himself liable to get into debt, or may perchance be forced to deny himself some of the necessities of life. The profession should look to its interests, and it can only do so in the matter by acting as a unit.

In adjusting what we consider our claims upon the community, we must not render ourselves liable to run into another extreme, by demanding anything more than what is our due. The evils of exorbitant charging are not only great, so far as they will prejudice the community against us, but as a body we ourselves would be seriously damaged, inasmuch as it would tempt us to lose sight of our sacred mission in the love for gain, thus degrading our profession to the level of the merest trade. The practitioner of medicine establishes for himself a certain *quid pro quo* for the treatment of a disease; but he is not prepared to admit that his services are only worth just so much, that his advice to the poor sufferer *can* be paid for in mere dollars and cents, but as a domestic economist he is entitled to a certain income to supply his wants, and by virtue of that alone does he feel, as a physician, that he is entitled to a fee.

With this view of the question, there is no need for any false delicacy in the matter, and we should not be at all backward in establishing such pecuniary relations to the public as we are really entitled to. As men of science and philanthropists, we look after the interests of the community in a manner which lays them under infinite obligations to us, and the least that they can do is to afford us a decent means of livelihood.

We think that the subject is one which should be agitated in professional circles, in order that some concerted action may be the result, and some uniform tariff of prices be at once determined upon.

THE WEEK.

At the recent International Congress held at Vienna, the health of armies and of recruits was a subject of discussion. The following allusion to the action taken, is from a newspaper correspondent:—

The fourth section reports on the health of the army, particularly of the recruits. Extreme opinions prevail about the sanitary condition of the army. The elaborate reports of Drissangel and Prof. Virchow have been an excellent basis for the labors of this section. The statistics of the sanitary condition of recruits is a most difficult subject. Their healthy condition represents a valuable capital. The section has come to the following resolutions:—

1. The Congress sees an excellent opportunity to obtain through recruits exact information of the sanitary condition of a large portion of the male population.
2. It is the wish of the section that all recruits be examined and their sanitary condition be investigated, not excepting those who are deficient in stature nor those altogether unfit.
3. Principal points to be inquired into.
 - (a) Place of nativity and occupation.
 - (b) Stature, weight, circumference, measure of breast. (The measurement to be taken in a quite uniform manner.)
 - (c) Statement of the morbid condition which caused unfitness for service. Exact tables, such as given in the

programme of the preparatory committee (too voluminous to be reproduced here), should be prepared. The Congress recommends urgently to the governments the acceptance of these resolutions. The programme contains most learned essays by Professor Virchow on this subject, which are recommended by the fourth section for the information and consideration of governments.

WE have several times alluded to the hospital cars recently constructed, at the suggestion of the Sanitary Commission. To Dr. ELISHA HARRIS is due the credit of devising them, and we are happy to know that they serve an admirable purpose. They are already to be placed on several of the most important railroads. A contemporary thus describes what it designates as the Harris hospital car:—

"The length is 41 1-2 feet, and the width 8 feet 7 inches. The car will accommodate thirty-six patients, with the requisite number of attendants, usually three or four—surgeon, steward, and two 'contrabands,' the patients being divided off as follows:—Twenty-four in beds, four on sofa, and six—the more convalescent—in easy chairs. Some idea may be formed of the thoughtfulness of Dr. Elisha Harris, of New York, the originator of these cars, when we state that in addition to all the mechanical comforts supplied in the build of the car, the following partial list of articles of the first quality is also provided:—24 stretchers, 31 pillows, 24 counterpanes, 24 pairs of socks, 30 pairs of slippers, 50 towels, 10 pair surgeon-splints, 15 gowns, 1 roll of lint, 25 handkerchiefs, cooking apparatus, case of medicine, beef-stock, coffee, milk, cups, pitchers, knives, tin plates, bandages, rubber air pillows, rubber pails and blankets, utensils for cleansing, canteens, fans, and jellies—making in all a complete and portable hospital. The facilities for ventilating the car cannot be surpassed for simplicity and efficacy. A free and pure current of air is constantly supplied, smoke and dust being ingeniously avoided. Every department, in fact, is so complete, that a simple description cannot do justice to the ingenuity displayed in each."

WHILE the citizens of New York have received with private and civic ovations the officers of the Russian fleet now in our harbor, the medical profession has extended to the surgeons of the fleet a cordial greeting. In another column we give the address of welcome of Dr. BUCK, on the part of the Academy, and the reply of a member of the Russian staff. Four members of the staff visited the Academy of Medicine at its last meeting, and were warmly welcomed by the President, Dr. Anderson, after which the meeting adjourned to that gentleman's house, where a social reunion was held.

Correspondence.

WOUNDS OF THE CAVITIES, VISCERA, AND BRAIN.

[Third letter of Dr. A. H. HOFF, Surg. U.S.V., to Prof. MARCH, of Brooklyn, N. Y.]

DEAR SIR:—I have expressed to you very freely my ideas in reference to resections, support of fractures, etc., etc., and I shall devote this letter to wounds of the cavities, viscera, and brain. Wounds of the chest are not as common as one would suppose. It is a singular fact, that the vast majority of wounds are of the extremities. However, it has been my fortune to have had placed in my charge quite a number wounded in the chest, and most of these several days after receiving the injury. The history of these cases, so far, does not endorse the determined

necessity of the peculiar treatment presented heretofore by many of our military surgeons. I find here, as well as everywhere, that we all are inclined to ride our hobby, some insisting upon one thing, and some upon another. But what has surprised me most, is the fact that in the midst of a multitude of opinions our patients recover with but little of our interference. I have not seen, so far, a single case of internal hemorrhage from a gunshot wound penetrating any of the cavities, supposing the reason to be that death invariably ensues within a short time after the wound is received. These cases that have come under my notice, have, so far, simply required care as to position, and a moderate degree of treatment, having a tendency to compose the nervous system, and hold in check inflammatory action.

Hearing the air rushing out through an aperture in a man's back, and through another in front on the opposite side, at every expiration, would incline one to make a very unfavorable prognosis; but to have the same man shake you by the hand six months after, with his musket slung across his shoulder, well and hearty, would lead you to ask how can this be, and what has been done to accomplish it. On inquiry, you find that first one hole closed up; then, after a little, it produced no inconvenience to stop up the other. The expectoration, which was somewhat troublesome and streaked with blood, continued for two or three days; then more oppression was felt, some twinging pains, respiration after reaching a certain point was painful, but the patient could get along without breathing so long; it did not seem necessary to support life that a full inspiration must be taken, and it could not be done, because it hurt; felt better in a semi-recumbent position, but found lying on the side, "scoop fashion," did just as well, and enabled him to sleep and let all the matter run out; had a first-rate appetite, but had to be careful not to fill his belly too full, as he could not breathe so well; washing him off with cold water now and then, first along with a patch spread on his breast, kept cool, felt first-rate, made him breathe easier, and then, keeping perfectly quiet, not talking any, and having folks keep away from him, saved his life. "Didn't take much doctor stuff; a little stuff now and then to make him sleep, and once, he believed, a little physic to open him." I have outlined this conversation for the purpose of pleasantly demonstrating what made a man so severely wounded feel comfortable, gleaming from it the following indications:—1st, Keep the orifice open. 2d, Be particular as to position, consulting the patient's feelings carefully, as he is the best judge. 3d, Keep the chest cool. 4th, Give free exit to all discharge. 5th, Quiet all irritation by keeping the patient perfectly quiet, giving anodynes, but with great care; be cautious about diet, more especially quantity, and meet with decision any untoward complication your watchfulness may discover. Don't think, because the wound is dreadful, the remedies must be dreadful with which you attack it. On looking over what I have written, I feel inclined to think you will laugh at me, but you know my hobby is to add the sufferer's opinion to my own thinking, thereby better to get at the indications; for he feels the pain, and I judge of the cause; he knows when it is relieved, I find out the reason. Nature cures, I do the best to assist. Allow me here to make this remark; on the battle-field it would be a troublesome matter to carry out the immediate treatment recommended for gunshot wounds of the chest accompanied with severe hemorrhage. I hope it will never be my fortune to receive one, as death would be my certain doom.—I find I have consumed all my time. The army is in front of Vicksburg; what is to be done. I have not been informed, but I am happy to say that the medical department out here is in first-rate condition; everything in readiness, let come what will.

U.S. Hospital Steamer D. A. JANUARY.
YOUNG'S POINT, La., March 29, 1868.

MINIE RIFLE BALL ENTERING THE BELLY AND ESCAPING BY THE RECTUM.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—In one of the late numbers of your Journal a correspondent has reported two cases of the escape of balls by the rectum. I wish to report a third.

On the twenty-ninth of March, 1863, I saw, in Hospital No. 8, at Louisville, Ky., Corporal John I. English, of the 5th Indiana Battery, who was wounded at Murfreesboro, on the thirty-first of December, 1862, by a conical ball, which entered just below and in front of the anterior superior spinous process of the ilium, on the left side. The ball escaped from the rectum on the fortieth day.

When I saw Corporal English he was in bed; the wound in front had closed, but matter continued to discharge by the rectum. His bowels were regular; but he was obliged to urinate often, and urination was attended with some pain. His health was steadily improving, and there was but little reason to doubt his final and complete recovery. The ball, which he showed me, was a little battered.

Very truly yours,

FRANK H. HAMILTON.

NEW YORK.

Army Medical Intelligence.

(CIRCULAR NO. 19.)

SURGEON-GENERAL'S OFFICE,
WASHINGTON, D.C., Sept. 2, 1868.

THE assignment of Officers in command of Companies of the Invalid Corps to General Hospitals, is for the purpose of increasing the efficiency of the Hospitals, and is a part of the hospital organization, under the senior Medical Officer.

They are, while on that duty, a portion of the Commissioned Staff of the Hospital, and are entitled to the same allowance of quarters, fuel, etc., within the Hospital, when at all practicable, as Medical Officers of similar rank.

It is confidently expected that much benefit will be derived from the provisions of General Orders No. 212, current series, and that Surgeons in charge of General Hospitals will endeavor to render the position of these Officers such that there will be entire harmony and concord of action in the performance of their respective duties.

By order:

C. H. CRANE,
Surgeon, U.S.A.

(CIRCULAR NO. 20.)

SURGEON-GENERAL'S OFFICE,
WASHINGTON CITY, Sept. 29, 1868.

Medical Directors, in cities where there are several General Hospitals, will designate one in each city at which enlisted men, requiring Trusses, will report themselves to the Surgeon in charge, to be measured for and fitted with the proper instruments. Medical Purveyors will cause to be made, and furnish, Trusses corresponding in measure and description with the requisition to be made in each case, in lieu of the usual issue, which will be discontinued to all General Hospitals where this arrangement can be carried into effect.

By order:

C. H. CRANE,
Surgeon, U.S.A.

ORDERS, CHANGES, &c.

Surgeon William S. King, U.S.A., has been relieved from duty as Medical Director, Department of the Susquehanna, and ordered to proceed to Lexington, Ky., and report in person to Major-General Burnside, commanding Department of the Ohio, for duty as Medical Director of that Department.

Surgeon Gleason S. Palmer, U.S.V., on duty at Chambersburg, Pa., has been ordered to report to Major-General Meade, for duty as Medical Director, 11th Army Corps.

Surgeon C. F. H. Campbell, U.S.V., on being relieved as Medical Director, 11th Army Corps, will report to the Medical Director, Department of the Susquehanna, for duty at Chambersburg, Pa.

In accordance with the findings of a military commission, convened by virtue of Special Orders No. 286, Headquarters District of Memphis, and by direction of the President, Assistant-Surgeon W. S. Bell, 43d Ohio Vols., has been dismissed the service of the United States for absence without leave.

The leave of absence heretofore granted Surgeon R. K. Smith, U.S.V., from the Headquarters Department of the Gulf, has been extended twenty days.

Edward Russell, late Surgeon 4th Louisiana Vols., dismissed as Assistant-Surgeon 26th Massachusetts Vols., by Special Orders No. 228, current series, has been restored to his regiment with pay from the date of rejoining it for duty, on condition that he shall refund to the Pay Department an over-payment of \$225.16, and provided the vacancy has not been filled, evidence of which must be obtained from the Governor or appointing authority.

The following named Medical Officers have been assigned to duty with the Army of the Potomac, to report in person without delay to Surgeon Jonathan Lettman, U.S.A., Medical Director of that Army.

Assistant-Surgeon E. J. Marsh, U.S.A., now on duty in Washington, D. C.

Assistant-Surgeon C. K. Winne, U.S.A., now on duty at Pittsburgh, Pa., Department of the Monongahela.

Assistant-Surgeon John Bell, U.S.A., now on sick leave, at the expiration of his leave.

Assistant-Surgeon Van Buren Hubbard, U.S.A., now in charge of U.S. General Hospital, Filbert street, Philadelphia, Pa.

Assistant-Surgeon Edward Brooks, U.S.A., now on duty in Baltimore, Md.

So much of Special Orders No. 408, September 17, 1868, from this Office, as directed Assistant-Surgeon W. C. Daniels, U.S.V., to report in person without delay to Major-General Grant, U.S.V., commanding Department of the Tennessee, is hereby revoked, and Surgeon Daniels will report at once to Major-General Burnside, U.S.V., commanding Department of the Ohio, for duty.

So much of Special Orders No. 294, July 3, 1868, as directed Surgeon Charles McCormick, U.S.A., to report in person to Brigadier-General Kelly, U.S.V., commanding Department of Western Virginia, for duty as Medical Director, has been revoked, and Surgeon McCormick will proceed without delay to Wilmington, Del., and relieve Surgeon John Campbell, U.S.A., as a member of the Retiring Board, convened by Special Orders No. 807, July 11, 1868, now in session at that place.

Surgeon Campbell on being relieved to proceed to the Headquarters Department of the Susquehanna, and report to Major-General Couch commanding, for duty as Medical Director.

By direction of the President, and upon the recommendation of the Board of Examiners, convened by Special Orders No. 294, July 3, 1868, Surgeon W. H. White, U.S.V., has been honorably discharged the service of the United States on account of physical disability, to date September 26, 1868.

Leave of absence has been granted to the following Medical Officers:—

Acting Assistant-Surgeon G. M. Paulin, U.S.A., for twelve days.

Assistant-Surgeon R. E. Wiesling, 1st District of Columbia Cavalry, for fifteen days.

Surgeon J. S. Hildreth, U.S.V., Desmarres Hospital, Washington, D. C., for fifteen days.

Surgeon James Bryan, U.S.V., is on sick leave at Philadelphia, Pa.

Surgeon John A. Liddell, U.S.V., has been granted twenty days' leave, on account of sickness.

Assistant-Surgeon W. C. Spencer, U.S.A., has been relieved as Medical Purveyor, Department of the Gulf, at New Orleans, La.

The following assignment of Medical Inspectors is hereby made:—

Lieutenant-Colonel E. P. Vollum, U.S.A., now stationed in Washington, D. C., to report in person to Major-General Rosecrans, commanding Department of the Cumberland, as Medical Inspector of that Department, and by letter to Assistant Surgeon-General Wood at St. Louis, Station, Nashville.

Lieutenant-Colonel Peter Pineo, U.S.A., now at Boston, Mass., awaiting orders, to report for duty as Medical Inspector to Major-General Gilmore, commanding Department of the South. Station, Hilton Head, S. C.

Lieutenant-Colonel Augustus C. Hamlin, U.S.A., now on duty in the Department of the South, to report to this city, and report in person to the Medical Inspector-General, U.S.A., as Medical Inspector of the Department of Washington.

Lieutenant-Colonel John Wilson, U.S.A., upon completion of special duty in Medical Inspector-General's Office, to report to Major-General Meade, commanding Army of the Potomac, as Medical Inspector of that Army. Station, Washington, D. C.

Lieutenant-Colonel N. S. Townsend, U.S.A., now on leave of absence, to report at the expiration of his leave to Assistant Surgeon-General R. C. Wood, at St. Louis, for assignment.

Lieutenant-Colonel George W. Stipp, U.S.A., now on leave of absence, to report at the expiration of his leave to Major-General Banks commanding Department of the Gulf, for duty as Medical Inspector of that Department. Station, New Orleans.

Lieutenant-Colonel John L. Le Conte, U.S.V., now on duty as Medical Inspector in the Department of the Missouri, to report to Major-General Couch, commanding Department of the Susquehanna, for duty as Medical Inspector of that Department. Station, Philadelphia, Pa.

The leave of absence granted Surgeon W. S. Forbes, U.S.V., in Special Orders 217, Headquarters Department of the Gulf, has been extended twenty days.

STATISTICS OF THE CAUSES OF EXEMPTION.—Provost Marshal-General Fry has issued a circular directing that immediately upon the completion of the draft in any district, the Surgeon of the Board of Enrolment therein will compile, and forward to the Provost Marshal-General's Office, the statistics of the causes of exemption, on account of physical disability, from such draft in his district. The report will show the whole number of men drafted in the district, with an alphabetical list of the several kinds of disability, and the number rejected for each, and will be accompanied by a detailed statement of such other facts as may be of scientific importance to the medical profession of the army.

Dr. Roger W. Pease (Surgeon New York Vols.), has been appointed Assistant-Surgeon U.S.V., to date October 2, 1868.

By direction of the President, Assistant-Surgeon L. H. Pease, 10th Connecticut Vols., has been dismissed the service of the United States.

Lieutenant-Colonel J. M. Cuyler, Medical Inspector U.S.A., has been directed to make a close inspection of the command in and near Norfolk and Portsmouth, Va., and the United States General Hospital at Old Point Comfort.

Surgeon R. B. Bontecou, U.S.V., has been relieved from duty in the South, and will report in person without delay to the Medical Director, Department of Washington, for duty in charge of the Harewood General Hospital.

Surgeon A. T. Augusta, 7th U.S. colored troops, is hereby relieved from duty at the Contraband camp near this city, and will report immediately to Surgeon Josiah Simpson, U.S.A., Medical Director, Baltimore, Md., for duty with his regiment.

A Board of Medical Officers, to consist of Surgeons J. J. B. Wright and E. H. Abadie, U.S.A., and Assistant-Surgeon J. H. Bill, U.S.A., will convene in New York city on the fifteenth day of October, 1868, or as soon thereafter as practicable, for the examination of candidates for the appointment of Assistant-Surgeons in the U.S.A., and of any Assistant-Surgeons for promotion who may be brought before it.

Assistant-Surgeon Wallace D. Martin, 62d Pennsylvania Vols., has been discharged the service of the United States on account of physical disability, and for absence without proper authority, as reported on the rolls of the regiment.

Permission to delay reporting to the Medical Director, Department of the Gulf (as directed by Special Orders 408, September 11, 1868, from the War Department), for fifteen days, is hereby granted Surgeon Thomas B. Reed, U.S.V.

Upon the report of a Board, organized by virtue of Special Field Orders No. 205, July 27, 1868, Headquarters Department of the Cumberland, Assistant-Surgeon Mordecai Brooks, 82d Indiana Vols., has been, by direction of the President, discharged the service of the United States for incompetency.

The leave of absence granted Surgeon Lincoln R. Stone, 54th Massachusetts Vols., in Special Orders No. 541, September 28, 1868, from Headquarters Department of the South, to enable him to appear before the Army Medical Board, now in session at Washington, for the examination of candidates for appointment of Surgeons and Assistant-Surgeons of Volunteers, has been extended ten days.

So much of Special Orders No. 438, September 27, 1868, from the Adjutant-General's Office, as directed Surgeon G. S. Palmer, U.S.V., to report to the Medical Director, Army of the Potomac, for duty as Medical Director, 11th Army Corps, is hereby revoked, and Surgeon Palmer will report for temporary duty at Carlisle, Pa., to relieve Surgeon J. J. B. Wright, U.S.A. On the return of Surgeon Wright to his duty at Carlisle, Pa., Surgeon Palmer will report by letter to the Surgeon-General for duty.

Permission to delay ten days en route to his station is granted Surgeon P. H. Humphreys, 35th New York Vols.

The leave of absence, heretofore granted Surgeon R. K. Smith, U.S. Vols., is extended ten days.

Leave of absence has been granted to:—

Surgeon J. M. Allen, 54th Pa. Vols., for fifteen days.

Assistant-Surgeon J. H. Williams, 123d Ohio Vols., for twenty days.

Surgeon Chas. O'Leary, U.S.V., for twenty days.

The following named commissioned officers have been detached from their respective commands, and ordered to report in person to Brigadier-General Wild, U.S.V., at Morris Island, S. C.

Assistant-Surgeon H. H. Mitchell, 39th Massachusetts Vols.

Assistant-Surgeon Arthur H. Cowdry, 7th Massachusetts Vols.

By direction of the President, Surgeon James C. Fisher, U.S.V., is hereby dismissed the service of the United States, for persistent failure in making to the Surgeon-General's Office, monthly reports of station and duties, as required by circular from that office.

Leave of absence has been granted to Assistant-Surgeon H. M. Sprague, U.S.A., for twenty days.

Surgeon E. J. Bailey, U.S.A., has been relieved from duty as a member of the Board to retire disabled officers, convened by Special Orders No. 807, July 11, 1868, and now in session at Wilmington, Del., and Surgeon Ebenezer Swift, U.S.A., is detailed as a member of said Board, in his place.

Surgeon W. C. Otterson, U.S.V., has been ordered to report to the Assistant Surgeon-General, at St. Louis, Mo., for hospital duty, as soon as his health will permit.

Surgeon Frederick Seymour, U.S.V., has been ordered to report to Nashville, Tenn., and settle his accounts and property returns.

Assistant Surgeons Gerhard Paul, H. L. W. Burritt, and Edwin Freeman, U.S.V., have been ordered to report to Surgeon J. E. McDonald, U.S.V., Medical Director 9th Army Corps, Department of the Ohio.

Surgeon F. A. Keffler, U.S.V., has relieved Assistant-Surgeon W. C. Spencer, U.S.A., as Medical Director, Department of the Gulf, at New Orleans, La.

The General Hospitals, Stanley and Foster, at Newbern, N. C., have been consolidated under the charge of Surgeon J. J. De Lamar, U.S.V.

A General Hospital is being established at Madison, Wisc., for the accommodation of Northwestern Volunteers.

Surgeon B. Beas, U.S.V., is on twenty days' leave at Weehawken, N. J.

Surgeon Snelling, U.S.V., has been assigned to the charge of the Chesapeake hospital, Fort Monroe, Va., relieving Surgeon A. E. Stocker, U.S.V., who will report to the Medical Director, Fort Monroe, for duty.

Surgeon C. Cowgill, U.S.V., in addition to his duties as Superintendent of General Hospitals for the District of North Carolina, will assume charge of the Contraband Department of the same District, and also perform the duty of Surgeon-in-Chief to the command of Brigadier-General Palmer.

Surgeon S. S. Schultz, U.S.V., has been transferred from Covington, Ky., to Madison, Ind.

Assistant-Surgeon Francis Greene, U.S.V., is in New York on sick leave from Department of the South.

Assistant-Surgeon A. B. Chapin, U.S.V., is sick in quarters at Annapolis Junction, Md.

The following officers are hereby honorably discharged the service of the United States on account of physical disability, with condition that they shall receive no final payments until they shall have satisfied the Pay Department that they are not indebted to the Government.

Assistant-Surgeon E. F. Spaulding, 7th Wisconsin Vols.
 Surgeon Levi Butler, 8d Minnesota Vols.

CIVILITIES TO THE MEDICAL STAFF OF THE IMPERIAL RUSSIAN ATLANTIC SQUADRON.

A DEPUTATION of the New York Academy of Medicine visited the flag-ship of the Russian squadron in our harbor, on Monday the 5th inst., and was most cordially received by the whole medical staff, assembled by previous appointment. After mutual greetings the company proceeded to the Admiral's cabin, where refreshments were provided. The Chairman of the deputation made a brief address in French to the Staff, welcoming them to our city in the name of the Academy, inviting them to be present at its regular meetings during their stay among us, and tendering such personal services as might render their visit agreeable and useful. A response was made in the same language by one of the Staff, heartily reciprocating the fraternal sentiments expressed by the deputation. An hour was then most agreeably spent in conversation and the interchange of mutual good wishes; another member of the Staff also addressed the deputation in English, reiterating the fraternal feelings which all present shared in. After being shown through the ship, and admiring the completeness of her equipment, and the admirable order everywhere conspicuous, the deputation took their leave, highly gratified with their visit.

The deputation, consisting of Drs. Buck, Post, and G. A. Peters, was accompanied by the following members of the Academy: Drs. Delafield, Bulkley, Detmold, Hubbard, Geo. T. Elliot, Joel Foster, Underhill, Noyes, and Bell of Brooklyn.

DR. BUCK made the following address:—

GENTLEMEN AND HONORED COLLEAGUES OF THE MEDICAL CORPS OF THE IMPERIAL RUSSIAN ATLANTIC SQUADRON:—As Delegates of the New York Academy of Medicine we come to welcome you to our city, and express the satisfaction afforded us by this first visit of a Russian squadron to our shores. We avail ourselves of the opportunity to extend to you a fraternal hand. Though separated by the Ocean we are members of the same honorable profession, everywhere laboring in the common cause of humanity and science, and animated by the same motives and aspirations. It affords us pleasure to-day to give expression to that international sympathy which subsists between our respective governments.

GENTLEMEN—The Academy of Medicine has specially charged us to invite you and your colleagues who are expected yet to arrive in our harbor, to be present at its regular meetings during your stay among us. We shall also be happy personally to render you any service that can contribute to make your visit agreeable and useful.

REPLY OF ONE OF THE MEDICAL STAFF.

I am happy, gentlemen, conjointly with my comrades, to greet you on this occasion, and grasp your hands, stretched out with so much friendliness and cordiality towards us, your brethren in science.

What confers an incontestable advantage on our profession, compared with others, is doubtless the absolute cosmopolitanism of the Medical art. For, whilst political combinations and other reasons render international relations sometimes friendly, sometimes hostile; whilst misunderstandings provoke bloody conflicts even among fraternal nations, of which we see unhappily sad examples at the present time in your country and our own; I will say further, whilst the fathers of churches make distinctions between their own flocks, Medicine alone never loses its

humane and philanthropic character; for there does not exist a country, however little civilized, where medical aid, even to a sworn enemy, is not the first and most sacred of duties.

We feel assured, gentlemen, that it is as much in the name of international sympathy as of science that you have opened your arms to us, your professional brethren; and we flatter ourselves that with the same kindness you will allow us to see your clinics, your hospitals, and other benevolent institutions, of which your imperial city possesses so great a number.

Thus deriving from your experience and your civilization treasures of science, we shall be able, with the liveliest gratitude, to impart to our colleagues in Russia the fruits of our observation among you, and teach them to appreciate, as we do, your kindness and national genius.

Medical News.

NEW YORK COUNTY MEDICAL SOCIETY.—At the Anniversary Meeting of the Medical Society of the County of New York, held Oct. 5, 1863, the following officers were elected for the ensuing year:—Alf. Underhill, M.D., President; Isaac E. Taylor, M.D., Vice President; Guido Furman, M.D., Recording Secretary; Henry S. Downs, M.D., Corresponding Secretary; S. T. Hubbard, M.D., Treasurer. H. D. Bulkley, M.D., E. R. Peaslee, M.D., Joel Foster, M.D., Jos. K. Merritt, M.D., and D. S. Conant, M.D., Censors; Drs. Jas. Kennedy and Jos. K. Merritt, Delegates to the State Med. Society for three years. The meeting was well attended, it being the largest one since Oct. 12, 1846, which was an adjourned anniversary meeting.

From the Secretary's report we learn that the "comitia minora" had held eleven, and the society nine meetings during the past year, and that twenty-three new members were admitted during the same period, and that no less than eleven members were removed by death during that time.

The hour being late, the election of delegates to the American Medical Association, and the appointment of committees, etc., will be continued at the adjourned anniversary meeting, on the first Monday of November next.

SURGEONS IN THE LIBBY PRISON AT RICHMOND.—The following is a list of the Union surgeons still held as prisoners in the Libby Prison at Richmond, contrary to all the positive and definite agreements hitherto made in regard to these prisoners.—Surgeons W. M. Houston, One Hundred and Twenty-second Ohio, captured June 15; W. F. McCurdy, Eighty-seventh Pennsylvania, June 15; Alston W. Whitney, Thirteenth Massachusetts, June 20; W. A. Rodgers, Third Tennessee, June 19; W. Spencer, Seventy-third Indiana, April 30; J. L. Morgan, Tenth Massachusetts, May 13; C. E. Goldsborough, Fifth Maryland, June 15; Lewis Applegate, One Hundred and Second New York, July 2; T. C. Smith, One Hundred and Sixteenth Ohio, June 15; A. A. Mann, First Rhode Island cavalry, June 18; R. P. McCandless, One Hundred and Tenth Ohio, June 16; A. S. Looker, Sixth Illinois cavalry, May 20; C. T. Simpers, Sixth Maryland, June 15; F. M. Patton, Twelfth Virginia, June 15; O. Nellis, Second Virginia cavalry, July 19; W. W. Myers, United States steamer Georgia, May 14; M. F. Bowen, Twelfth Pennsylvania cavalry, July 15; J. L. Brown, One Hundred and Sixteenth Ohio, June 15; — Ketchum, Eighty-third New York, June 29; D. B. Wren, Seventy-fifth Ohio, June 20.

D. H. STEUDNER, one of the staff of the German expedition to Central Africa under Baron Henglin, has died of fever after having passed through the dangerous miasmata of the morasses of the White Nile.

MARRIAGE.

CRAMTON—WARD. Married, on the thirtieth of September, by the Rev. Geo. W. Ranslow, J. O. Cramton, M.D., of Fairfield, Vt., to Miss Lottie E. Ward, of Milton.

SPECIAL NOTICES.

NEW YORK MEDICAL COLLEGE.—*The regular course of this Institution will commence on Tuesday, the 20th. The Introductory Lecture will be delivered by Prof. A. JACOBI on that day, at 8 P.M.*

NEW YORK ACADEMY OF MEDICINE.—*On Wednesday, Oct. 21st, at 8 o'clock, Dr. J. L. LEAMING will read a memoir of GEORGE P. CAMMANN, M.D., late Fellow, after which Dr. M. BLUMENTHAL will read a paper on Vulva Vaginitis of Children and Young Girls, with a special reference to violence and injuries in the latter; to be followed by remarks by Drs. F. BARKER, GARDNER, and others.*

SECTION OF SURGERY AND SURGICAL PATHOLOGY.—*A Stated Meeting of this Section will be held at the residence of the Chairman, Dr. JAMES R. WOOD, No. 2 Irving Place, on Friday, October 23, at 8 o'clock P.M.*

SUBJECT FOR DISCUSSION:—*Espediency of Amputation of the Thigh, either in its Continuity or at the Hip-Joint, in Gunshot Fractures.*

N. Y. OPHTHALMIC SCHOOL.—*Dr. MARK STEPHENSON will deliver the Introductory to his Twelfth Course of Lectures on the Anatomy, Pathology, and Treatment of Diseases of the Eye, at the N. Y. Ophthalmic Hospital, cor. 4th Avenue and 28th Street, on Saturday, October 17th, at 4 o'clock P.M. Students of medicine and the profession are invited to attend.*

N.B.—Cliniques every Tuesday, Thursday, and Saturday, from 1½ to 3½ P.M.

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JOSEPH MATHER SMITH, M.D., Professor of Materia Medica and Clinical Medicine.

ROBERT WATTS, M.D., Professor of Anatomy.

WILLARD PARKER, M.D., Professor of the Principles and Practice of Surgery and Surgical Anatomy.

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ALONZO CLARK, M.D., Professor of Pathology and Practical Medicine.

JOHN C. DALTON, JR., M.D., Professor of Physiology and Microscopic Anatomy.

SAMUEL ST. JOHN, M.D., Professor of Chemistry.

THOS. M. MARKOE, M.D., Adjunct Professor of Surgery.

WILLIAM DETMOLD, M.D., Professor of Military Surgery and Hygiene.

T. G. THOMAS, M.D., Adjunct Professor of Obstetrics.

HENRY B. SANDS, M.D., Demonstrator of Anatomy.

The Preliminary Term for the Session of 1863-4 will commence on MONDAY, SEPTEMBER 21st, and continue four weeks, until the opening of the Regular Term in October.

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A deduction of 10 per cent is made for 6 insertions.

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